MO HealthNet

MANAGED CARE SUBSTANCE ABUSE SCREENING & REFERRAL FORM

MEMBER INFORMATION			PROVIDER INFORMATION			
Name (Last, First	t, M.I.)	Date of Birth	Provider Name (affix label here)			
Address (Street, City, State, Zip Code)		MO HealthNet Number	Address			
CCN		l l				
SSN						
MO HealthNet Managed Care Health Plan			MO HealthNet Provider Number			
Phone Number			Email			
Date of Office Visit			Signature Da	Date		
STEP 1	Does member: ☐ drink alcohol? ☐ use illegal drugs? ☐ abuse prescription med					
What						
prompted this screening?						
ocreening.						
If pregnant, trimester of pregnancy:						
STEP 2 CAGE-AID [CAGE Adapted to Include Drugs]				Yes	No	
Call Have you felt you ought to cut down on your drinking or drug use?						
A: Have people annoyed you by criticizing your drinking or drug use?						
G: Have you felt bad or guilty about your drinking or drug use?						
E: Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover						
(eye opener)?						
STEP 3 Disposition:						
☐ Brief Intervention ☐ Referred to						
If referred, primary reason for referral and other pertinent information (attach separate sheet if necessary):						